EXHIBIT B

IN THE UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF MICHIGAN

SOUTHERN DIVISION

KOHCHISE JACKSON, Case No.: 2:19-cv-13382

Plaintiff, Honorable

vs. Terrence G. Berg

CORIZON HEALTH, Inc., et al., Magistrate: Patricia T. Morris

Defendants.

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Pages 1-102

The Virtual, Videotaped Deposition of Jeffrey Bomber, D.O., taken pursuant to Notice in the above-entitled cause, via Zoom, on May 28, 2021, at 11:00 a.m., before Carol Marie Hicks, CSR-3345, Notary Public in and for the County of Livingston.

APPEARANCES:

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Keith Papendick, M.D.

ALSO PRESENT: STEVE ALFONSI, VIDEOGRAPHER

(All parties appeared via Zoom.)

INDEX TO EXAMINATIONS

EXHIBITS

EXHIBITS - (cont'd.)

(Attached.)

May 28, 2021

At or about 11:00 a.m.

JEFFREY BOMBER, D.O.,

having first been duly sworn, was examined and testified on his oath as follows:

THE VIDEOGRAPHER: We're now on the record. This is the video-recorded deposition of Dr. Jeffrey Bomber, being taken virtually. Today is May 28, 2021, and the time is 11 a.m. Would the attorneys please identify themselves and the court reporter please swear in the witness.

MR. CROSS: Good morning. Ian Cross on behalf of the plaintiff Kohchise Jackson.

MR. WILLIS: Good morning. Kenneth Willis on behalf of defendant Prime Healthcare Services and Colleen Spencer.

MR. SCARBER: Good morning. Devlin Scarber appearing on behalf of the Corizon defendants in this case, Corizon and Dr. Papendick.

JEFFREY BOMBER, D.O.,

having first been duly sworn, was examined and testified on his oath as follows:

EXAMINATION

BY MR. CROSS:

Q Good morning, Dr. Bomber. Have you ever had your

deposition taken before?

A Yes, I have.

Q So I'm just going to go over some ground rules, even though you probably already know. I need verbal responses, no head nod, head shaking, so that the court reporter can get something on the record. It's not an endurance test. If you need a break, if you need to use the bathroom, just let me know, and we'll take a break. I'd just ask that you answer the last question that I pose before the break, okay?

A Yes.

Q And if you don't understand any of my questions, I don't want you to guess, I want you to ask me to clarify, all right?

A Yes.

Q All right. When was the last time you were deposed?

A Last time I was deposed; approximately one year ago.

Q Do you remember what case it was?

A I believe it was -- there were a couple of cases in a row, so I'd have to look back at the record.

Q Okay. So, there was one involving a gentleman by the name of Kensu; is that correct?

A I appeared in court for a Kensu case, and did one deposition, as well, for a Kensu case.

Q Okay. And there was a Spiller?
A Yes, I recall a Spiller.
Q And there was an Estate of Franklin?
A I recall a Franklin.
Q And there was an estate of Warren?
A Warren, yes.
Q Are there any that I'm missing?
A Those are the ones that come to mind right now.
Q But it's possible there's another?
A It's possible.
Q Okay. Can you give me a run down of your employment history since 2009.
A In 2009 I served as the site medical provider at the Newberry Correctional Facility, and also worked at Helen Newberry Joy as a staff physician. Subsequent to that, I became the northern regional medical director for PHS, which is now Corizon Health.
Q Okay. How long did you do that?
A I was a northern regional medical director for six years.
Q What were your duties as a northern regional medical director?
A My duties were to supervise the medical providers in the region.
Q What did you do after you were the northern regional

medical director?

A After I was the northern regional medical director I became the state medical director for Corizon Health.

Q And when did that -- was that a promotion?

A Yes.

Q When did you get that promotion?

A I served as state medical director for four years, so that would be from 2015 through August of 2019.

Q And you are no longer the state medical director?

A I am not. I concluded that in August of 2019.

Q So what have you done for a living between August 2019 and the present?

A I am a staff physician at Schoolcraft Memorial Hospital in Manistique, Michigan, and I'm the medical director for the Naubinway Rural Health Clinic, and I also consult with Corizon Health. I'm a contract employee, still, for Corizon Health.

Q So why did you cease to be the state medical director?

A I was the medical director for four years, and it required living in Lansing for a significant amount of time, and my main home is in Naubinway, and I was ready to be back home.

Q I see. And what are your duties now as a contractor

for Corizon Health?

A As a contract employee I help to supervise the providers at seven sites in the northern region.

Q So how is that different from when you were the northern regional medical director?

A Well, I only have seven sites at this time. When I was the northern director, I had 21 sites.

Q Oh, okay. So is there another individual who's now the northern regional medical director?

A The sites have been redistributed.

Q Was there ever a time when you worked in utilization management, perhaps temporarily, due to a vacancy?

A Yes, when I was the northern regional medical director we were without a utilization management physician for a couple of months and so all of us pitched in for that time period. The state medical director at the time was Dr. Orlebeck and I was one of her regional medical directors and we assisted with the process.

Q Can you describe what you did, what those temporary duties consisted of.

A Yes. So, there's a form, a No. 407, which is an MDOC form, that a provider completes in order to request a specialty service of some type, and that request is reviewed by the utilization management

physician.

Q Okay. And what does the utilization management physician do when reviewing that request?

A They review it for medical necessary; and, if medical necessity is demonstrated, the procedure or the referral is approved or an alternative treatment plan is offered.

Q All right. In your current position as a contractor, are you able to hire medical providers?

A I am involved in the hiring process, I'm part of the interview team.

Q Were you able to hire medical providers when you were the regional medical director for the northern region?

A Yes; again, I was part of a team, it was a team evaluation.

Q I see. Do you train the providers?

A I trained the providers up until the time I became state medical director.

Q And have you trained new providers since you became a contractor?

A I have not trained them in the formal sense -- formal sense being when we met with them and went over the training materials -- I don't do that anymore. I do follow up with them, do phone

meetings and chart reviews in order to make sure that they're acclimating and doing well.

Q Okay. Tell me about the onboarding process for a new provider; what training materials do they receive, if any?

A So, they -- before COVID -- they would have two days of training in the Lansing office, in person, with an RMD and review the Corizon provider training manual; they would also have training in IT for the electronic medical record; and there were also modules required by the Michigan Department of Corrections.

Q So, in the course of the onboarding process, did the new provider ever watch a video?

A I do not recall any videos.

Q Are there any quizzes that they have to take?

A There was a questionnaire, I believe it was based on the clinical modules; I think there was a module on diabetes, prostate cancer, a couple others. So there were some questions, medical questions.

(Bomber Deposition Exhibit No. 2 was marked for identification.)

Q Okay. I'm going to show you an exhibit. We'll call this Plaintiff's Exhibit 2. Can you see the document?

A Yes, I can.
Q You recognize it?
A That looks like, yeah, the "Practitioner Clinical Onboarding Checklist."
Q Okay. Did you provide any of the training in this checklist to new providers?
A I did provide some of the training, yes.
Q Was there another person who provided other portions of the training?
A Yes, there are other people.
Q Who are they?
A The office manager, the IT director, and the regional operations manager.
Q And are those Corizon employees?
A Yes.
Q And regional operations manager is what you said?
A Yes. Oh, and some of the siting -- some of the training was done on-site with the MDOC health unit manager.
Q Okay. So HUM did some of it.
A Correct.
Q So this is Corizon's training; is there a separate set of modules that are MDOC training that they also received?
A Yes, there are modules. Most of those deal with

safety in the correctional environment.

Q So, can you point out which portion of this onboarding you were responsible for providing the training for.

A Sure. I would review the "Corizon Culture of Patient Safety" in our patient safety program; I would review --

Q Where is that? Culture of patient, okay.

A Yeah, I would review that portion. I would review some of it in "The Correctional Environment"; of course, some of that is done with the MDOC and on-site. We would review the "Behavioral Health" section; we would review the "Correctional Healthcare Policies and Procedures," I believe all of those were reviewed; I would review the "Documentation and Medical Records"; and the "Utilization Management portion; and "Pharmacy."

Q How about in Phase II --

A And that's down on that page.

Q -- were you involved in any of these trainings?

A The "Correctional Environment" would be done on-site with the HUM.

Q Um-hum.

A The "Medical Management Model: Decision Support System," that would be done by me or the regional

medical director; the pharmacy training, a lot of that had to do with the IT and how to put in orders so IT would do part of that and we would do part of the pharmacy training; the "Quality Improvement Program," yes, we would do that; and the "Behavioral Health," we would do that; under "Legal and Risk Management," I recall some training on forensics and patient safety reporting; "Correctional Healthcare Policies and Procedures," we also reviewed, we reviewed those as well.

Q Okay. And this first part, "Accountable Care in the Patient Centered Medical Home Environment," who was responsible for this section?

A I was responsible for the "Corizon Culture of Patient Safety." I'm not sure, I would think the regional managers did the "Accountable Care Organization" sections. The "Contract Overview," the "Full Risk, Shared Risk, Pass Through," I'm not familiar with what all those mean. So that would be something that operations and office manager would train on.

Q Who is the regional operations manager?

A The head, VP of operations, Mason Gill; and he has had several people over the last ten years report to him, generally, there are two; I believe, currently,

it's Sara Goff.

Q Sara Goff. So she would be the one to do the first section, like the "Contract Overview, Full Risk Shared Risk, Pass Through"?

A Right, that wasn't a medical part. We focused on the medical parts. Anything that deal with operations, they would have to do.

Q So, you said you did this "Quality Improvement Program" section?

A Yes.

Q I want to direct your attention to the second to last bullet point, "Key performance indicators, slash, Process Indicators and Quality Indicators." What is that?

A I didn't calculate or have anything to do with those KPIs. We did report quality data to the MDOC, as required in the contract.

Q Well, I'm asking you what you trained the new providers about with respect to that issue.

A We trained the providers on what quality indicators the Michigan Department of Correction tracked.

Q What about key performance indicators? What did you teach them about key performance indicators?

A Nothing.

Q Nothing?

A Nothing.
Q Does Corizon have any key performance indicators, that you're aware of?
MR. SCARBER: I'll just make an objection to form; broad, overbroad base. But if the witness can go, go ahead.
A I do not have anything to do with key performance indicators or calculations. I'm familiar with the term, and I do believe that the corporate office does have KPIs.
BY MR. CROSS:
Q So what's a KPI?
A As I -- and, again, we don't use the term -- we don't use the term when discussing the quality indicators with the Michigan Department of Corrections. But I believe healthcare organizations use KPIs to track emergency room runs, hospitalization days, all-around utilization.
Q All-around utilization; what do you mean by that?
A So, if I have a patient go to the ER and utilize the ER, that's a utilization.
Q So ER runs would be a KPI?
A Again, I don't calculate them. I don't look at the data. I can't tell I exactly what Corizon's KPIs are.

Q Okay. I'm going to show you another document.

THE COURT REPORTER: And are you marking these as exhibits, Mr. Cross?

MR. CROSS: Yes, the previous one was Exhibit 2.

(Bomber Deposition Exhibit No. 3 was marked for identification.)

BY MR. CROSS:

Q I'm sorry, can you see the document?

A Yes.

Q Have you ever interacted with this Bethany Chester person in a professional capacity?

A Yes.

Q She work for Corizon?

A Yes.

Q I want to direct your attention to the second dash -- well, what is this document, first of all? What does it appear to be?

A It looks like a job description.

MR. SCARBER: Is that a resume? I'm sorry, Ian.

MR. CROSS: I think it's a resume.

MR. SCARBER: Okay. I mean, I see --

A I don't know.

MR. SCARBER: He's looking at

segments of it 'cause the way it was being scrolled down.

A Yeah, now I see the name. So, I guess, it looks like a resume.

BY MR. CROSS:

Q Okay. I want to go to the second dash in her "Professional Experience"; it says, "Creating, maintaining, managing emergency room, inpatient, hospice and palliative care, utilization management and COVID-19 data for monthly reporting to state medical director and Michigan Department of Corrections." You were the state medical director after October of 2017; is that correct?

A Correct.

Q Did you receive monthly reports containing emergency room, inpatient, hospice and palliative care, utilization management, et cetera, data from this Bethany Chester person?

A Yes. If you look at the MDOC contract, those numbers are required, that we are required to report those numbers to the Michigan Department of Corrections on a monthly basis.

Q And she didn't just report those numbers to the Michigan Department of Corrections, she also reported them to you, right?

A Well, to me, but the numbers were shared as part of the monthly report with the Department.
Q So did you -- you received the report, Exhibit 1?
A Yes.
Q What did you do with that data?
A It was given to the MDOC in a monthly report.
Q So the only reason it came to you was for to you give it to the MDOC?
A No, several people help write that report, including myself.
Q Okay. So you participate in creating a report for the MDOC --
A Yes.
Q -- containing all of this data.
A Yes, there's a whole list of the required numbers in the contract.
Q And is the only reason that Corizon tracks that data to comply with the contractual requirement to report it to the MDOC?
A I can't tell you all the reasons Corizon would track that data.
Q Can you tell me any of the reasons?
MR. SCARBER: I'll just place an objection; calls for speculation.
A My role was to provide the numbers per the

contractual agreement.

BY MR. CROSS:

Q So you can't tell me any of the reasons?

MR. SCARBER: Just going to place another objection; asked and answered.

A I can't tell you the reasons Corizon would want to see the data. I can tell you that I needed to see the data because it was required that I report that to the Michigan Department of Corrections.

BY MR. CROSS:

Q Okay. So, does Corizon track any performance measures or indicators for the MDOC contract?

MR. SCARBER: Just going to place an objection; that seems like that was asked and answered and it's been discussed over the last several minutes of your questions. But to the extent it's a different question or you have a different answer.

A I do not have a different answer. My requirement was to provide the data to the Department of Corrections.

BY MR. CROSS:

Q I'm not asking if you provided data to the Department of Corrections. I'm asking if Corizon tracks any performance measures or indicators for

the MDOC contract, to your knowledge?

MR. SCARBER: Objection; asked and answered.

A I believe that they looked at the monthly reports that we provided to the DOC; beyond that, I don't know.

BY MR. CROSS:

Q All right. I'm going to show you another document. We'll mark this Plaintiff's Exhibit 4.

(Bomber Deposition Exhibit No. 4 was marked for identification.)

Q Have you ever used a computer program that looks like that, sir?

A I have not used it. I know that Corizon has something called InGauge that they used to use for their utilization management. We didn't use the data.

Q So, who uses InGauge?

A I believe corporate, it's used at the corporate level.

Q So that would be, what, C Suite executives?

MR. SCARBER: I'm going to place an objection; calls for speculation; if you know, any more than you said.

A I know Corizon leadership looks at InGauge.

BY MR. CROSS:

Q So you've never used this.

A I've not used their data, no. We generated our data for the DOC from the electronic medical record, as well as the inpatient team and the on-site utilization management clerks and RNs.

Q Do you know if this program is still in use?

A I, frankly, don't. Like I said, I don't use it.

Q Okay. If I wanted to talk to someone who uses it, who would that be?

A That would be somebody at the corporate level for Corizon.

Q What's the corporate level? What does that mean?

A That would mean those at the Corizon headquarters Nashville, Tennessee.

Q Okay. So no one in Michigan uses this.

A We don't use it.

Q What is utilization management?

A Utilization management is monitoring the amount of utilization in a medical contract.

Q What's the purpose of utilization management?

A From my point of view, providing numbers to the Michigan Department of Corrections, as contractually obligated to; also, to monitor, like, if there's been an intervention. For example, when we started

to utilize the Impact Pro, we wanted to ensure that quality measures were being met and that inmates were -- we were ensuring that inmates were getting their medical needs met. So we would monitor the number of referrals, for example, to make sure that they were getting adequate care.

Q So the purpose of utilization management is to report data to the MDOC?

A No, and also monitor the quality of care.

Q Monitor the quality of care. So, when you were acting as a utilization review physician, in a temporary capacity, you were monitoring the quality of care?

A As a utilization management physician, I was monitoring the off-site referral request, ensuring medical necessity, and approving or giving an ATP.

Q I see. Does the utilization management physician reviewer consider costs when making his or her decisions?

A No, cost is never an issue in anything we do as medical providers.

Q So utilization management never considers cost.

A Not from my perspective; in fact, we're instructed by operations to practice medicine based on medical necessity, not cost.

Q Not cost. Okay. Well, that's -- let me show you another document. Hold on, this is -- got this clock in the way so I can't click on it. Here we go. Can you see the document, sir?

A Yes.

Q All right. For the record, this is a 30(b)(6) deposition you gave in Estate of Franklin. And I would like you to read out loud, for the record, lines 10 through 12 on this page.

MR. SCARBER: Let me have an opportunity to review the document, counsel. What lines do you want him to review?

MR. CROSS: 10 through 12.

MR. SCARBER: Okay.

MR. CROSS: We'll call this exhibit -- what are we on, 6?

MR. SCARBER: I thought the last one you said was 3.

MR. CROSS: All right, 4, then.

MR. SCARBER: I don't know. You better ask Carol.

THE COURT REPORTER: I don't know because I'm not marking them, I don't know.

MR. SCARBER: Okay. Maybe ken got another one, I was right and you could have said

another one, I'm not sure. Hang on.

MR. WILLIS: I only heard 3 or for the last one, I think, but I could be wrong.

BY MR. CROSS:

Q This InGauge screenshot, we'll call this Exhibit 4, and then I haven't shown you another one since this, before the deposition transcript, so we'll call the deposition transcript -- you know, we'll call it 7, 'cause I've already saved a couple as 5 and 6.

So could you read lines 10 through 12 of this transcript for the record?

A Sure.

"And that the utilization management component of the review process takes into consideration cost, correct"?

"Yes."

Did you say line 13, too?

Q Nope.

A Okay.

Q So it sounds like your testimony, in this case, was that the utilization management component of the review process -- well, this review process, I want you to look at lines 3 through 8, so we know what review process we're talking about here.

MR. SCARBER: Well, hang on, I'm

going to object to form, 'cause it sounds like you were asking him a question and now you're asking him to review something again.

MR. CROSS: Okay.

MR. SCARBER: So what do you want him to look at now?

MR. CROSS: Lines 3 through 8, or 3 through 9.

MR. SCARBER: Okay. Hang on. Take a look at that. Okay. Go ahead.

BY MR. CROSS:

Q Okay. So would it be fair to say that your testimony, in this case, was that the utilization management component of the 407 review process takes into consideration cost?

MR. SCARBER: I'm going to place an objection that it looks like it's taken out of context, so I object to form and mischaracterization of the document. But go ahead.

A So the context is as a provider, as a utilization management reviewer, as a state medical director, I do not consider costs, it's always medical necessity.

Yes, I'm sure that at the -- probably the DOC and at the corporate level they do review

costs. But, yes, they do consider costs. On a daily basis, I don't think about cost.

Q So what were you talking about here in this testimony when you said it "takes into consideration costs"? "Yes."

MR. SCARBER: Let me place another objection. I mean, to give him two lines out of a, it looks like this is page 232 of a deposition, and ask him what he was talking about, I think, is an unfair question. So I object that the -- I'll object to form and taking the document out of context.

MR. CROSS: I'll object to your speaking objection.

MR. SCARBER: Can you tell him what you were talking about in just one page of a 200-page deposition?

THE WITNESS: I'm speculating.

MR. SCARBER: Okay.

MR. CROSS: Devlin, you're coaching the witness.

MR. SCARBER: You just asked the witness, with all due respect, counsel, to tell him what he was talking about after reading 12 lines of a deposition.

MR. CROSS: If you'd like to read more of it, he can.

MR. SCARBER: He's not going to sit here and read -- the question has to be a question he can answer without reading 100 pages or 200 pages of a deposition. I mean, if you want to put it in some kind of context, that's fine. But my objection is to form, and I'm not trying to coach the witness on this, but I think it's -- I think it's an unfair question that requires a very detailed objection.

(Bomber Deposition Exhibit No. 5 was marked for identification.)

BY MR. CROSS:

Q Okay. Let's move on. I'm going to show you what's been marked Plaintiff's Exhibit 5. Have you ever interacted with this Lori Mignon Ernst individual in a professional capacity?

A Yes.

Q Okay. You know who she is?

A Yes.

Q And what is this document, for the record?

A It looks like another resume.

Q Okay. I want to direct your attention to the one, two, three, four, fifth dash here, under "Director of Utilization Management: Set up UM processes

within each region with CCO/COO to ensure maximum effectiveness" -- oh, I'm sorry, the next one -- strike that. "Work with CCO/RMD within regions to identify barriers and to find solutions for problems and align the contract in meeting with UM targets."

A Yes, I see it.

Q Did Ms. Ernst ever work with you to align the Michigan contract in meeting with UM targets?

A No.

Q Is it fair to say that UM stands for utilization management?

A Yes.

Q Okay. Did anyone work with you to align the Michigan contract in meeting with utilization management targets?

A I'm not even sure how targets is defined.

Q Well, how would you define it?

A I have no idea how they define it, it's not given here.

MR. SCARBER: And let me just place an objection as to foundation. This isn't his resume, he didn't draft this, he has no idea what this stuff means.

BY MR. CROSS:

Q So you testified that you have interacted with

Ms. Ernst in a professional capacity, correct?

A Correct.

Q And between 2013 and 2015, you were the regional medical director, that was your title, correct?

A Yes.

Q So, if Ms. Ernst is saying that she worked with RMD, does RMD stand for regional medical director?

A Yes.

Q So what did you -- strike that. When you worked with Ms. Ernst, what did you do?

A So, my main interaction with Ms. Ernst was when we went to a centralized model for utilization management, our portion, our participation for Michigan.

Q Are there utilization management targets for the Michigan contract?

A No.

Q Were there ever utilization management targets for the Michigan contract?

A Not for me, sir, never.

Q Not for you, sir? What do you mean by that?

A Not for the medical providers, not for the regional medical directors, we were never given targets.

Q So who are the targets for?

A I don't even know how they're defined. I would just

be guessing.
Q All right. The next one in this resume, "Daily review of Pipes/QNXT"; do you know what that is?
A I do not.
Q "Reports including inpatient tracking and outpatient referrals of all contacts to monitor and ensure compliance with targeted budget."
Is there a targeted budget for the MDOC contracts for Corizon?
A I'm not sure what targeted budget is. We did have a budget from the DOC contract. I have no idea what a targeted budget is.
Q How is the budget set?
A Well, there were a certain number of dollars over a five-year period that were allotted for medical management.
Q By Corizon.
A No, actually, by the DOC; that was in the DOC contract.
Q So there's a contract with the DOC that states how much the DOC is paying Corizon for medical management, correct --
A Yes.
Q -- more or less? And then does Corizon internally have a budget for how much it wants to spend on

medical management in Michigan?

A I would -- I think. I don't know.

Q You don't know anything about that.

A I don't have anything to do with preparing those budgets, if they exist.

Q And you don't know how reviewing inpatient tracking and outpatient referrals could help ensure compliance with the targeted budget?

A I would be speculating. I have no part in that.

Q Okay. So you testified that your interactions with Ms. Ernst were primarily related to a move to centralize utilization management?

A Yes.

(Bomber Deposition Exhibit No. 6 was marked for identification.)

Q All right. Let's look at what we will call Plaintiff's Exhibit 6. And this resume was 5, in case I forgot to note it. And this is Bates 103, the "Utilization Management Manual," produced by Corizon. So, see here it says the "Utilization Management Core Process will launch in January of 2017"?

A Yes, I see that.

Q What is the Utilization Management Core Process?

A I believe that was when we went to the centralized

UM process.
Q And how is that different from the previous practice?
A In the previous practice, there was just one utilization management physician. But in the new practice now, Dr. Papendick, who's currently the UMMD for the Michigan contract, is now supported by two other utilization management physicians; he has back up and support, you know, if he needs vacation or whatever. So those physicians are now all Corizon employees.
Q So Dr. Papendick is a Corizon employee?
A I don't know what -- if he's Quality Correction or Corizon now. I haven't been the state medical director for going on two years, so I'm not sure what his current designation is.
Q When you were the state medical director, were you a Corizon employee?
A No, I was employed by Quality Correctional Care of Michigan.
Q What is Quality Correctional Care of Michigan?
A Quality Correctional Care of Michigan is a professional corporation, a PC.
Q In, say, 2017, who was the president of Quality Correctional Care of Michigan?

A I was.
Q And this is a corporation, correct?
A A professional corporation.
Q Who were the shareholders of Quality Correctional Care of Michigan, PC?
A I believe there was myself and Dr. Sylvia McQueen.
Q Dr. Sylvia McQueen; is she licensed to practice medicine in Michigan?
A I don't know.

(Bomber Deposition Exhibit No. 1 was marked for identification.)

Q All right. I'm going to show you what's been marked Plaintiff's Exhibit 1; and this is from the LARA Corporations Online Filing System; and it says the names and addresses of all shareholders, and we just have one shareholder here, and that would be you, correct?
A It looks like it.
Q So you were the sole shareholder of this corporation.

MR. SCARBER: I'm just going to place an objection only to a time -- a point in time, like when is it dated or when is this from?

MR. CROSS: This was filed in 2018.

MR. SCARBER: Okay.

BY MR. CROSS:

Q So, did Quality Correctional -- what is this -- Quality Correctional Care of Michigan, PC, make a profit in that year?

A No, there's no profit, none.

Q Did it lose money?

A You'd have to ask the operations director because I believe there may have been a loss year. But that would be information you'd have to obtain from operations. It was, essentially, a nonprofit.

Q It was a nonprofit.

A Essentially, it was a way -- in Michigan you can only practice medicine under, I think it's four different entities, and a PC is one of them. So Corizon would contract with Quality Correctional Care to provide the medical care to provide the providers.

Q Did Quality Correctional Care of Michigan have any other clients other than Corizon?

A No.

Q Does Quality Correctional Care of Michigan have any plans for mass layoffs in the near future?

MR. SCARBER: Let me just place an objection to relevance, and, you know, asking about the business decisions, which are probably

proprietary or confidential concerning a defendant that's not even in the case or party that's not even in the case. But go ahead, if you can answer.

A I'm not a part of the leadership with Quality Correctional Care, so I don't know.

BY MR. CROSS:

Q Okay. Is it fair to say that Quality Correctional Care passes through its expenses to Corizon?

A Yes.

Q Okay. So let's go back to what we were talking about before. This is Exhibit 6, the "Utilization Management Core Process."

I want to direct your attention to this section about how the success of the program will be measured. It says, "We will focus specifically on outpatient referrals per thousand, claims per thousand, referrals per UMMD, claims without a referral, ATPs and percent ATPs overturned."

What's the difference between outpatient referrals per thousand and claims per thousand?

A I'm not sure. It's nothing that we tracked or presented. I would speculate that the outpatient referrals are the pure number of patients referred;

and, claims, that would, to me, infer that there was some sort of cost claim made or charge associated with that.

Q Like a dollar amount.

A Yeah, like if you go to the emergency room there's, you know, a cost associated with that; or if you see a specialist, there's an office fee; if they do a surgery, there'd be a surgery fee. That's generally what I understand to be a claim. So that specialist would file a claim or a charge.

Q All right. And see this, like, first clear, or not filled-in, bullet point here that says, "30/60/90 day review RMDs and UMMDs"?

A I see it.

Q Were you involved in those 30-, 60- or 90-day reviews of the success of this program?

A No.

Q Okay. Do you know how a metric like outpatient referrals per thousand would indicate success versus failure of this program?

A I wasn't part of the development of that program nor was I part of the ongoing meetings with that program; it wasn't part of my job description, my duties.

Q Okay. So, let's go to this section about how RMDs

will monitor and remain knowledgeable of referral and ATP activity. "RMDs will review: Detailed daily reports of all ATPs." Did you do that?

A Yeah, as you can see in the monthly report to the DOC, we did report the percentage of ATPs.

Q And was the only reason you did that to report it to the DOC?

A Well, I certainly wouldn't want the number of ATPs to start going up. So I would look at it to make sure that we were, you know, at or around our average, because we want to make sure that the inmates are getting the care that they need. So we would look at it from a quality point of view.

Q So is there a goal or target for the percentage of ATPs that are -- I mean -- or, I'm sorry, the percentage of requests that are approved versus ATP'd?

A There's no goal or requirement, that I'm aware of. We did track it to make sure that, if there was a trend, we'd want to explain why.

Q Okay. Is that something you track at the individual provider level?

A We would look at that in the beginning with a new provider. Often, when you first get into the system and you're learning how to use Uptodate and learning

the referral system, a new provider might have a higher number of ATPs, and so we would help them be able to write more detailed and more medically necessary type referrals.

As far as tracking it provider by provider, there were times where we did that. It wasn't anything that we did regularly.

Q So when would you do that?

A There were a couple of times where the Michigan Department of Corrections requested that, so we did provide that data.

Q I'm going to take you down a page, this is still the same exhibit. This chart here, does that accurately represent the workflow of the Utilization Management Core Process, as you understand it?

A It's very small and I would need a few minutes to look at it.

Q All right.

A Actually, I have to take my glasses off to do -- oh, we have a copy right here. Okay. Yeah, this looks to be the process that's being used now.

Q Okay. Let's go through it. So it starts with the outpatient referral request; that's done by a medical provider at the site, correct?

A Yes.

Q And if that request is missing information or it's not detailed enough, there's this UM nurse review, and it looks like there's an arrow that goes back to the provider. So would the UM nurse determine if there wasn't enough information in the request and then ask the provider to resubmit it, if that the case?

A Not resubmit. If there was a missing section, a blank part of the form, the provider would give that information to the UM nurse and they would complete the same 407. So they wouldn't have to file a new one.

Q Okay. So the UM nurse makes sure that the request is complete.

A Correct.

Q And it has all the information that the physician reviewer would need to make a decision.

A From a clerical point of view, not a medical decision-making point of view.

Q Okay. But she's not making the medical decision, but she's making sure that there's enough information for a physician to make a medical decision.

A Correct.

Q Okay. So then the next box we have is called pass

through list. What's that?

A That would be like a pacemaker check; automatic approvals.

Q All right. So there's a list of things that are automatically approved.

A Correct.

Q And if it's on the pass through list, then we get a yes, and we go directly to referral authorized, right?

A Correct.

Q And does the physician reviewer determine if the procedure is on the pass through list?

A That list was developed by physicians.

Q Okay. But the person who compares the request to the list, is that a physician?

A No, they review the pass through list, and, if it's appropriate for that, it's automatically given an authorization.

Q Okay. And that's the nurse reviewer who does that?

A Correct.

Q Okay. Now, if it's not on the pass through list, then it goes to the utilization management medical director, right?

A Yes.

Q And it goes to him via, what, an email?

A Yes, it's -- well, now it's all electronic now.
Q Okay.
A Yes.
Q If I say the word "407 group," do you know what that is?
A That's the email group that the 407 request is sent out to.
Q And who's in the email group?
A That would be the provider, the UMMD nurse and provider, and then whoever on-site helps to manage the 407 process, usually the HUM, as well as the health information manager.
Q And are those sent to the Michigan.gov emails for these individuals or are they sent to Corizon health emails?
A That would all be through the EMR now. So, back then, it would be through the DOC email process.
Q So the email is within the EMR?
A Yeah, now there are messages within the EMR regarding the 407s. I believe they still have the email groups, though, too.
Q So if I were to order a prisoner's medical records, they would include those messages or would they not?
MR. SCARBER: Just going to place an objection to foundation, as to whether he would know

that. But go ahead.

A I'm not sure.

MR. SCARBER: And my objection, Ian, is, more or less, he doesn't know what the MDOC would give you or be able to produce for you because I think your question asked 'if you ordered records, what would you get'?

MR. CROSS: Okay.

MR. SCARBER: That's the basis of my objection.

A I don't know.

BY MR. CROSS:

Q And you believe it would be the Michigan.gov emails for those people would receive --

A Yes.

Q -- those messages? Okay. So, where were we? On UMMD review. Now, if the UMMD approves the request, it goes to the UM nurse, who adds detail attributes. What does that mean?

A Well, there has to be an authorization number attached now to the 407 so that whoever the specialist or whatever the provider is has an authorization number.

Q So the UM nurse adds an authorization number and then the referral is authorized?

A Correct.
Q So once the UMMD approves, there's no one else who has to approve the referral, it's done?
A Correct.
Q All right. Now, if the UMMD does not approve, are they required to issue an alternative treatment plan?
A Yes.
Q The UMMD cannot deny without issuing an alternative treatment plan, correct?
A There is no such thing as deny.
Q Okay.
A It's either approved or given an alternative treatment plan.
Q And is the alternative treatment plan typically something that can be done on-site at the prison?
A Not always. It could be that the UMMD physician thought that an ultrasound may be more appropriate than a CT scan. So it may be an alteration in the request or given an ATP, such as self -- a home exercise program, which can be done on-site. So it could be either.
Q Could be either. Does the UMMD physician have access to any information that the site physicians don't have access to, in terms of what is medically

indicated for a given problem?

A Site providers have access to whatever they need; they're provided a subscription to Uptodate; They're -- I don't know if it's the same. I can tell you that they both have adequate resources.

Q So the site provider has Uptodate and the UMMD also have Uptodate.

A Correct.

Q And the UMMD uses Uptodate to make his determinations?

MR. SCARBER: I'm just going to place an objection to foundation. Are you asking what he does or what somebody else might do or what they're supposed to do? I guess that's my question; form.

BY MR. CROSS:

Q Okay. So what did you do when you were doing this?

A As a site provider?

Q No, as a UMMD, as a reviewer.

A Oh, for the two months when I did that? Yes, I would utilize Uptodate, at the time, was my main resource; also, the National Cancer website information, sometimes. Mostly Uptodate.

Q Okay. So if you -- if an alternative treatment plan is issued, then the ATP goes to the site provider for review, correct?

A Correct.
Q And the site provider has two options: They can either accept the ATP or they cannot accept the ATP.
A That's correct.
Q And this not accepting the ATP, that's referred to as an appeal?
A Yes, then they have the right to appeal.
Q How common are appeals?
A I can't quantify it for you. Generally, I understand, currently, there are one or two a week.
Q Has that volume changed at all in your time with Corizon?
A No, it seems to be somewhat steady.
Q Okay. Do you know about how many alternative treatment plans there are a week?
A I do not know that, no.
Q So, if the site provider does not accept the ATP, then it goes to the regional medical director, which, at one point, was you, correct?
A Correct.
Q And do these appeals go to you now in your current role?
A Yes.
Q All right. And are you able to unilaterally overturn the ATP?

A No, not as a regional director.
Q Not as a regional director. So you have two options: You can uphold the ATP, right?
A Correct.
Q And then you would discuss that with the site provider, and that would be the end of the process.
A No.
Q No? I mean -- so here I see the arrow goes to uphold ATP, nurse acknowledges, site provider accepts ATP.
A No, that is not our process in Michigan.
Q So beside upholding, you have another option, you can appeal the ATP, right?
A Correct.
Q So it comes to you, you can't say, 'I overturn,' but you can uphold or you can appeal again to the CMO. Who's the CMO?
A So this doesn't delineate the entire process in Michigan. But the pathway that you just asked me a question on: If the provider comes to me and appeals it, then I send that appeal to the CMO or SMD, state medical director, RMD, council, which meets three times a week, and we discuss the appeal.
Q So the appeals -- you're saying, in Michigan, appeals don't go to the Corizon CMO.

A No, no, not -- no. Go ahead.
Q This is not an accurate description of the process.
A No, no. There are some components not included in this document.
Q All right. So the RMD gets it; the RMD appeals it to the state medical director; you used to be the state medical director; then what happens?
A It's the state medical director -- there's a council that meets, it includes the state medical director, the regional medical director, and they then decide whether or not to overturn the ATP or uphold the ATP.
Q So that's kind of like this appeals committee review up here.
A I have to look closer. No, it's not exactly like that, because ultimately the chief medical officer of the state of Michigan has the ultimate authority. So, can I walk you through the actual process?
Q Yeah, yeah, go ahead.
A Okay. So, we're at the appeal level. So the RMD appeals to the state medical director RMD council; and if they uphold the ATP, the provider still has another option and that is to appeal to the chief medical officer of the state of Michigan that has ultimate authority, they can do that there; and

then, also, if I uphold the ATP, the provider always has the option to go to the chief medical officer for the state of Michigan. There's several levels of appeal.

MR. SCARBER: When you say "state of Michigan," are you talking about, what, what -- Corizon or another entity?

MR. CROSS: I'm asking the questions here.

MR. SCARBER: I understand, but I need to be clear.

THE WITNESS: So it's just between Corizon and DOC. At this point, there's no one from Corizon corporate involved in the process.

BY MR. CROSS:

Q All right. Can the prisoner initiate the appeal process?

A They have a system of grievances.

Q I understand they can file a grievance, and that's handled by the MDOC, right?

A Correct.

Q But can they initiate the Corizon appeal process that you just described?

A No, I don't believe so.

Q Okay. Does Corizon review the performance of

site-level medical providers?

A There's an annual review process, yes.

Q Have you ever done any kind of performance review of a provider as an RMD or state medical director?

A Yes.

(Bomber Deposition Exhibit No. 8 was marked for identification.)

Q All right. I'm going to show you what we will call Exhibit 8. Do you recognize this document? I mean not what's filled out in it, but just the form itself?

A It's not -- it looks like a document that's similar to what we review. We used to review providers in Michigan, but it's not exactly the same, this is a little different.

Q How is it different?

A Well, the form is a little different, the organization is different; some of the questions are similar, though.

Q Okay. Tell me how the form is different; what are the differences, what are the different questions?

A Well, I'd have to have the other form in front of me. It's just the way it's organized, the lines, the boxes, they're all a little different.

Q Interesting. And you know who this person Keith

Papendick is, right?
A Yes.
Q And what's his job?
A He is a utilization management physician.
Q And do you know who this person, James Powell, is?
A That would be Dr. Powell, who used to be the chief medical officer of Corizon.
Q Okay. So I'm noticing on this form -- like, let me direct your attention to No. 5, "Demonstrates compassion in patient encounters, NA"; that would stand for not applicable, right? Is that a fair assumption?
A That question, seems to me, would be directed towards someone who's seeing patients eye to eye, face to face.
Q Exactly. And does Dr. Papendick, in his current role, see patients eye to eye, face to face?
A No.
Q So, this form probably isn't specific to utilization management medical directors, is it?
MR. SCARBER: Just going to place an objection to speculation and foundation. But go ahead.
A I can't answer that question 'cause I didn't develop this form nor do I use this exact form.

BY MR. CROSS:

Q Okay. Do you have access to the form that you do use?

A Not immediately, no.

Q So, I want to direct your attention to the Medical/ Clinical Judgment Section." On the form that you use, is there something similar to No. 3, "Prescribes pharmaceutical therapy within the guidelines of Corizon Health or contracted formulary"?

A There is a question around pharmacy and pharmaceutical use. Can't tell you exactly if it reads the same, there is a question.

Q There's a question like that?

A Yes.

Q And what would be the answer that would reflect better on the site provider, yes or no?

A Yes.

Q Yes. What's a formulary?

A A formulary is a list of medications provided by any healthcare organization. The MDOC has a formulary and we're -- that's preferred that we use a drug on the formulary. It's not the only drugs we can use, but those are the preferred medications.

Q What's the purpose of having a drug formulary?

A A drug, what, I'm sorry?
Q What is the purpose of having a drug formulary?
A Purpose of having a drug formulary is to make sure that you provide medications in every category needed for the patients.
Q Well, wouldn't you be able to provide medications in every category needed for the patients without a drug formulary?
MR. SCARBER: Just going to place an objection to relevance. Go ahead.
A I know there are other reasons for having a formulary; health entities, hospitals, for example, clinics, are provided better cost in volume buying participating in a formulary.
BY MR. CROSS:
Q So is part of the reason that a health care organization would use a drug formulary to control costs?
MR. SCARBER: Place an objection as speculation and mischaracterizes his testimony. But go ahead.
A They use it to provide better pricing and help with cost, yes.
BY MR. CROSS:
Q Okay. And so below this question you have a --

strike that. See where it says, "Percentage of non-formulary medication on-site"?

A Yeah, I can tell you we don't track that for the providers.

Q You don't?

A No.

Q All right. Do you track the number of UM requests during the last year for the providers?

A We do not, and there's a question on that, we just don't have the data available. So, no, we don't discuss that in our reviews.

Q Do you track the percentage of requests that are approved?

A We track the overall -- now we track the overall percent of ATPs, yes.

Q But do you track the percentage of an individual providers' 407 requests that are approved?

A Previously, I was asked that question, and I did answer that question before, and, yes, intermittently that number has been tracked and provided to the DOC.

Q Do you use that number at all in evaluating the performance of the individual provider?

A I don't, no.

Q Did Corizon ever use that number in evaluating the

performance of the individual provider?

A Not actively.

Q What do you mean by "not actively"?

A That number may have been provided intermittently to us and the providers. But it was not a part of their annual assessment, it wasn't a factor in evaluating them.

Q If a provider has something like a 50 percent ATP approval rate, would they receive any kind of coaching or performance improvement plan?

A Intermittently, like I said earlier, typically that would be a new provider who just needs some coaching to help learn the system better. Most of our providers are overall seasoned. We have many providers that have been with us for many years, and they don't have many ATPs.

Q They don't have many ATPs at all or they don't have many ATPs as a percentage of their requests?

A There are some providers who have virtually hundred percent of their 407s approved, and, you know, others 90, 85 percent. Occasionally, like I say, we get somebody who has a lower approval rate and we want to make sure that they have the tools required to be successful.

Q So if someone has a -- if a provider has a lower

approval rate, what changes do they need to make to be more successful?

A Generally, their 407s don't include enough information or they haven't demonstrated medical necessity.

Q So if it doesn't include enough information -- we were talking before about this nurse reviewer -- hold on -- this nurse review portion of the "Utilization Management Core Process Workflow" --

A Right.

Q -- where the nurse should help them correct that before it even gets to the physician reviewer, right?

A Usually, yes.

Q So if they're not including enough information, shouldn't that not really affect their ATP percentage because it gets fixed before it gets to the doctor?

A Yeah, we've improved that part. So, you're correct, that would be a very, very small percentage of them now.

Q Okay. So, usually, if their percentage is -- their approval rate is low, it's because they're requesting things that aren't medically necessary?

A Yes.

Q So how does Corizon define medially necessary?
A Well, the MDOC has policies, and we also use Uptodate, sometimes available other medical literature, whatever is required.
Q So you're telling me that there are some MDOC policies that indicate what's medically necessary and what's not medically necessary?
A Yes, there are some policies. They also use InterQual.
Q Does the MDOC have a definition of medical necessity?
A I don't think so, per se.
Q Has the standard of what meets medical necessity changed at all over the course of your time working in the Michigan prison system?
A Only in the sense that Uptodate changes every day.
Q All right. So what's the definition of medical necessity that you apply?
A So, medical necessity is based on the medical literature and the standard of care. So any procedure, intervention, is based on the medical evidence whether or not it's necessary.
Q What do you mean by "necessary"?
A So, you know, in medicine we have a saying, 'Do no harm,' and if we order a test we want to make sure

that that test will be the appropriate test and also be thinking that it may lead to other procedures, so want to make sure that it's the right type of imaging, for example. We want to make sure that the -- there are -- you know, everything in medicine we weigh the risk versus benefit. So the benefit of a treatment or a procedure should outweigh any risk, based on the medical evidence.

Q So if the benefit outweighs the risk is the procedure then medically necessary?

A No, that's only part of my answer.

Q That's only part of it? What else -- so you have to have benefit outweighing risk; what else do you need?

MR. SCARBER: I'm just going to place an objection; asked and answered in his last answer. He mentioned a number of things that go into it.

BY MR. CROSS:

Q You may answer.

A So, yeah, there are numerous research studies and FDA approvals, et cetera, to lead to the determination of medical necessity and benefit versus risk.

Q All right. So you're talking about efficacy and evidence-based medicine; is that right?

A Correct.
Q So if there is research that indicates that the requested service, whatever it is, is effective for the condition, whatever it is, and the benefit of the service or procedure outweighs the risk, it is then medically necessary?
A You have to take it by -- patient by patient, you have to individualize this. You can't just make a blanket -- there are some generalizations, but you just can't just make a blanket statement.
Q Did you review any documents in preparation for today's deposition?
A Yes.
Q What documents did you review?
A I only reviewed documents provided by my attorney.
Q Did you review any medical records?
A I reviewed portions of medical records I was provided by my attorney.
Q Did you review medical records for an individual by the name of Kohchise Jackson?
A Yes.
Q What medical records did you review?
A There were excerpts from his chart, I believe; there was a 407 request.
Q What else?

A I would have to have my attorney provide those documents again.

MR. SCARBER: Ian, we gave him the MDOC chart, he looked through that. I can't say he looked at every page, but he had that to skim through.

BY MR. CROSS:

Q All right. Did you receive any records about Mr. Jackson's treatment after he left the MDOC or before he entered the MDOC?

A I believe there was a document related to his time in a jail.

Q Okay. How about afterwards?

A I did not see any medical records afterwards, that I recall.

Q Have you ever met Mr. Jackson?

A No, with the caveat being that I do visit a lot of sites and do meet patients intermittently, but I can't say for sure.

Q Okay. But fair to say you've never evaluated him as a medical provider.

A No, I have not evaluated him.

Q Did you form any opinions about whether any procedures were medically necessary on the basis of your review of medical records for Mr. Jackson?

A Yes, there was a request for revision of a colostomy.
Q And you formed an opinion about whether reversing that colostomy was medically necessary; is that correct?
A Yes.
Q Based on your review of those medical records.
A Medical records and MDOC policy, yes.
Q Okay. So MDOC policy determines what's medically necessary?
A No.
Q So, then, how did MDOC policy factor into your clinical judgment about whether a colostomy reversal was medically necessary?
A MDOC has policies based on medical necessity. They don't do the research that determines medical necessity, but their policies are based on medical necessity.
Q Okay. But is it fair to say that you were able to form an opinion about whether a colostomy reversal was medically necessary or not based on reviewing medical records?
A No, I would review Uptodate and see what the current recommendation is, whether it's medically necessary.
Q So you looked at Uptodate and you looked at medical

records?

A I have looked at Uptodate on a daily basis. I can't say that I looked at colostomy reversal in the last month, but I have reviewed that before.

Q Okay. But you were able to form an opinion on the basis of the medical records you reviewed in preparation for today's deposition and your experience and what you previously read on Uptodate?

A Yes.

Q Okay. So if I were to show you some medical records for Mr. Jackson from a time period after he was released from the Michigan Department of Corrections, would you be able to form a medical opinion about whether or not colostomy reversal was appropriate or medically necessary at that time?

A I can't say, I'd have to review the information.

Q And --

MR. SCARBER: Let me just place an objection to this line of questioning. This witness isn't a named defendant in this particular case. There is no allegations about whether this witness' medical judgment was involved in making the decisions in this particular case; and, you know, he's not really a part of the claim that's being made here.

MR. CROSS: Is he going to testify about whether or not colostomy reversal is medically necessary?

MR. SCARBER: Are you talking about at the time that the request was made or are you talking about two-and-a-half years later?

MR. CROSS: I'm talking about at either time.

MR. SCARBER: If you're going to ask him the question, I suppose he could answer the question as to what was necessary at that particular time. But this is way outside the scope of what your claim is. And I don't want to go any further, you know, making any speaking objections, but my objection is that that's not what this witness is here for. He's not here to establish any standard of care testimony for your guy or your standard of care of testimony with respect to what happened later in the case with Dr. Weber or anything of that nature, if that's where you're going with it.

If you're going to ask him about the 407 process, what was presented based upon what he's seen from the 407 process at that particular time in April of 2017 or that summer, based upon whatever was submitted or whatever the appeal or the

grievance was, I mean, obviously, I think that's pertinent.

MR. CROSS: But you don't think it's pertinent to ask him about -- well --

MR. SCARBER: It doesn't matter if I think it's pertinent. I guess what I'm saying is that's my objection.

MR. CROSS: Okay.

MR. SCARBER: And I'll reserve it. I mean, you can ask him -- you certainly can -- if you got a question to ask, I'll make my objection as you ask it. I was just laying the foundation so that I didn't have to keep objecting to a whole bunch of questions that you might ask. But go ahead.

BY MR. CROSS:

Q Okay. So did you apply the same definition of medical necessity you just discussed when you were doing utilization review?

A Yes, the literature and the MDOC policy on revisions, I think, is very clear.

Q So who trained you to do utilization review?

A That would be my predecessor as state medical director, was Dr. Orlebeck.

Q And she taught you what constitutes medical necessity?

A No.
Q No? Who taught you that?
A We use Uptodate, InterQual and other relevant medical literature to determine medical necessity.
Q So you look at the literature and if the literature indicates that a given treatment is, well, effective and the benefit outweighs the risk, is it then medically necessary or is there something else that you need?
A I would ask what is the consensus opinion, what does Uptodate say.
Q All right. Let me give you an example: Say a patient has cataracts, dense cataracts in both eyes; is it medically necessary to remove both cataracts or is it just good enough to remove one?
A I'd really have to know about the particular inmate and their symptoms. I'd have to have more details than that.
Q What details would you need?
MR. SCARBER: Just going to place an objection to asked and answered.
A I'd want to know more about the inmate, what's his vision, does he meet the medically necessary criteria.

BY MR. CROSS:

Q So that's what I'm getting at here. What is the necessary medical criteria?

MR. SCARBER: Objection; asked and answered now quite a few times.

A About cataract removal, I would have to look it up.

BY MR. CROSS:

Q So there's a specific policy somewhere about cataract removal and when it's medically necessary to remove a cataract?

A No, consensus opinion and Uptodate, for example, is where I would look.

Q So you would look at Uptodate and see if Uptodate says do it, then you do it?

MR. SCARBER: Objection; mischaracterizes his testimony about -- I won't make a speaking objection. But he's already given you indications as to what might help his decision as to medical necessity.

A There are other guidelines. Medicare, I believe, has guidelines for cataract removal.

BY MR. CROSS:

Q So if something meets Medicare's guidelines, is it -- of medical necessity, is it then medically necessary, according to Corizon?

A It's multifactorial. I'm just trying to explain that there's not just one thing that we look at, but Uptodate is our core resource.

Q All right. Is it possible that Corizon's definition of medical necessity is more restrictive than Medicare's?

A Wow. I couldn't really answer that. You're talking about a lot of information. I just really couldn't answer that.

Q Well, are there some procedures that Medicare would consider medically necessary and pay for that Corizon would not do for a prisoner?

A I can't answer that, there's just too many variables.

MR. CROSS: Why don't we take a break now.

THE VIDEOGRAPHER: Going off the record, the time is 12:33 p.m.

(Break was taken.)

THE VIDEOGRAPHER: We're back on the record. The time is 12:52 p.m.

BY MR. CROSS:

Q Okay. I'm going to take you back to Exhibit 6, this Utilization Management Manual, the portion about the UM core process. See where it says here, at the

bottom, that some training will be provided to support a successful launch?

A Yes.

Q Did you receive any training in connection with the launch of the UM core process?

A Yes, we received training and we did review the process.

Q All right. How was the training provided?

A I believe there was some live training, as well as some virtual training.

Q Virtual training, interesting. How did you do the virtual training?

A With -- actually, I think, Mignon, at one time, did some training.

THE COURT REPORTER: Excuse me, what was that?

A Yes, I did receive training, yes.

Q Okay. Did you -- were there any materials provided to you during that training?

A I can't recall precisely what was provided, there were some materials.

Q What kind of materials?

A I think there was an algorithm similar to the one you showed me about -- it was focusing on the process and procedure that is what happens to the

407 once it's generated, who it goes to, and the appeal process. That's what the focus of that training was.

Q So was it this manual? Is that what you were shown?

A No, we weren't trained in this manual. There are parts of it, perhaps, but I didn't see this particular manual that you're showing me.

Q Okay. Did you go through a training module called RMD Utilization Management 101?

A I don't think so, no.

Q So the online training, was it live or was it recorded?

A There were --

MR. SCARBER: Just going to place an objection; I don't know if he said "online" or if he said "virtual." But go ahead.

A Yeah, no, it was live, either telephone or virtual.

BY MR. CROSS:

Q Do you know if that session was recorded?

A I do not.

Q Okay. And the in-person training, where did that take place?

A There was training at our annual state-wide meeting.

Q Who provided that training?

A I believe it was actually one of the VPs of

operation and Mignon Ernst.

Q Did they give you any handouts or did they put up a PowerPoint slide, any kind of the materials, or did they just talk?

A There were materials. I don't have them.

Q Do you remember what they were?

A There were some -- there was a PowerPoint presentation at the state-wide meeting.

Q Okay.

A And then there were subsequent calls, group calls.

Q Do you know what a 30(b)(6) witness is?

A I believe that is where you testify on behalf of a corporation.

Q And you get specific subjects you're going to testify about, correct?

A Correct.

Q And you have to become reasonably knowledgeable about those subjects before you testify, correct?

A Correct.

Q Have you ever been a 30(b)(6) witness for Corizon?

A Yes, but, I'm sorry, sometimes the numbers or the designations are confusing.

Q Were you ever designated to testify about Corizon's document retention policies?

A I may have been asked a question about them. But I

don't have anything to do with their document retention.

Q So you're not familiar with their document retention policies at all.

A No, I'm not a part of what happens at the corporate level.

Q Okay. Do you have a computer at work?

A Yes.

Q Do you need to retain documents that you create on your computer, pursuant to a policy?

A Pursuant to a policy. I had -- at one time, I had the MDOC policies and procedures and a copy of the contract. I do -- the Corizon forms, I do have the annual review form for providers on my computer. But I don't retain any documents for the company.

Q All right. Is there like a provider handbook or a manual that's provided to Corizon providers in Michigan?

A Yes.

Q Do you have access to that document?

A Yes, there are hard copies in the Lansing office.

Q And what's the title of it?

A Corizon Provider Training Manual?

Q Corizon Provider Training Manual? Okay. Is there a virtual version that providers can access online?

A Not that I'm aware of. I have not.
Q Okay. I'm going to go back to this deposition you gave in Franklin. So here, at 15 through 16, you said, "The resources are now part of the onboarding manual which is available via the web to the providers." Do you have any idea what resources you were talking about there?
A I don't believe that ever materialized. That's what we were told was going to happen to it. But during my tenure, it actually did not.
Q And then at line 23 to 24, you were asked, "So it's an online manual now"? And you said, "Yes."
A Yes.
Q But, in fact, it was not actually an online manual?
A That was my understanding, that it was going to be online and was online, but it did not materialize.
Q Okay. So, in your opinion, is it medically necessary to reverse a functional colostomy, ever?
MR. SCARBER: Just going to place an objection to relevance, foundation. But go ahead.
A My opinion is based on medical necessity as per Uptodate and following MDOC policy. I'm not an expert in colostomies.
BY MR. CROSS:
Q Okay. What MDOC policy are you referring to, sir?

A There is a policy that discusses cosmetic surgeries; and under their policy, colostomy reversal is considered more of a cosmetic procedure, and that is not approved.

Q So you're saying there's an MDOC policy that prohibits cosmetic surgeries; is that correct?

A Yes.

Q And under that policy a colostomy reversal is considered cosmetic.

A They refer to it as being part of a cosmetic group, yes.

Q What differentiates a cosmetic from a non-cosmetic surgical procedure?

A You'd have to ask the MDOC how they define that. But a cosmetic procedure is meant to reverse the way something looks.

Q Okay. So this policy that you're talking about, does it specifically say that colostomy reversals are cosmetic?

A I did see the policy prior to this deposition today, and it is present. Is it okay to refer to that policy?

Q Sure. Yeah.

A Do you want to bring it up or you want me to just to --

Q I'll need a second to grab it. But I think I can bring it up here. Let me find that policy. And you have a copy in front of you?

A I do.

MR. SCARBER: We have one, Ian.

BY MR. CROSS:

Q Okay, let me just find it myself. What's the policy number?

A It's Policy Directive No. 03.04.100.

Q All right, 03.04.100, and what version of the policy are you referring to?

A The effective date is 2-1-2015, but this was filed -- oh, no, that's an evidence number, right? So, yeah, 2-1-2015.

Q All right. So we're looking at the same policy right now.

A Okay.

Q What portion of the policy indicates that a colostomy reversal is cosmetic?

A So they state under Section AA and BB, "Corrective surgery is a surgical procedure to alter or adjust body parts or the body's structure. Reconstructive surgery is a surgical procedure to reform body structure or correct defects. For purposes of this policy, corrective and reconstructive surgery does

not include procedures which can be done under local anesthesia. Corrective and reconstructive surgeries shall be authorized by a prisoner only if determined medically necessary and only if approved by the CMO. It shall not be approved if the sole purpose is to improve appearance."

Q Okay. So I don't see anything in that policy specifically about colostomy reversals. Can you explain how you believe that policy prohibits colostomy reversals.

A That's what we were told by the MDOC, that they consider colostomy reversals to be under this particular policy.

Q So is a colostomy reversal a reconstructive surgery or a corrective surgery?

A I -- again, I'm not an expert in interpreting that. It looks like the MDOC considers it a reconstructive-type surgery.

Q Okay. And does this policy say that corrective and reconstructive surgeries are not permitted for prisoners?

MR. SCARBER: Just going to place an objection; the policy speaks for itself, he didn't write the policy; and object to speculation as to what's meant by it, other than what the MDOC has

already told the inmate. Go ahead, if you can answer.

A It does state only if determined medically necessary and only if approved by the chief medical officer, which would be the chief medical officer of the MDOC.

BY MR. CROSS:

Q In your time as a provider for the MDOC, are you aware of any prisoners who received a surgery to reform body structure or correct defects?

A Well, correcting defects can be interpreted much more broadly in the face of an orthopedic injury, for example, that affects function, which may be medically necessary. So, in that context, certainly.

Q Are you aware of any inmates who received a surgical procedure to alter or adjust body parts during your time as a provider?

A Not for cosmetic purposes, no.

Q Okay. So cosmetic purposes means what? The sole purpose is to improve appearance?

MR. SCARBER: Just going to object to form, and asked and answered already.

A That's what the policy says.

BY MR. CROSS:

Q Do you think the sole purpose of reversing a colostomy is to improve appearance?

A I can tell you it's not considered medically necessary with -- according to Uptodate; and if it's not medically necessary, no, we don't approve them.

Q So do you think it was medically necessary in June of 2019 after Mr. Jackson got out of MDOC custody?

A I couldn't say. I don't have that information.

Q What information would you need?

A What was the patient presenting with, what was the opinion of the surgeon, what was the reasoning of it.

Q All right. I want to you assume, for the purposes of this question, that the patient's presentation at the time he received the surgery was the same in all material respects to his presentation when the surgical request was ATP'd while he was in the MDOC.

A So I don't understand what that presentation has to do with the policy that we were instructed to follow at the time.

Q It's not about the policy, sir, it's about what is medically necessary. So you're saying that the reversal surgery wasn't medically necessary because of the policy or because of the state of medical

practice?
A That was not only the policy, that's, I believe, what even the patient's own surgeon said at the time.
Q Was it not medically necessary because of this policy or was it not medically necessary because of the state of medical practice?
MR. SCARBER: Just going to place an objection, asked and answered.
A Right, there's no evidence I'm aware of that says that it's medically necessary.
BY MR. CROSS:
Q So why isn't it medically necessary?
MR. SCARBER: Just place an objection to asked and answered, now quite a few times, again.
A Well, we'd had have to go and look at all the literature that resulted in that consensus opinion. So it would be a number of reasons it's considered not necessary.
BY MR. CROSS:
Q Are you aware that the colostomy was eventually reversed?
A Yes.
Q So do you think that -- hold on. Strike that. Are you aware that the Michigan Medicaid program was

billed for the cost of the reversal surgery?

A No.

Q All right. Well, I want to you just assume that it's true. Are you aware that medical necessity is a condition of payment under both the Medicare and the Michigan Medicaid programs?

A I've not seen the language.

Q Are you aware that a physician who directly or indirectly seeks reimbursement from Michigan Medicaid for a service that is not medically necessary is committing healthcare fraud, a ten-year felony?

A As you say.

Q So do you think Dr. Weber, the doctor who reversed Mr. Jackson's colostomy shortly after he was released from prison, committed healthcare fraud?

A I cannot speak to the specifics of that case.

Q So, the way I see it, there are three possibilities here: Either, one, his condition changed between the time he was in prison and the time that he was released such that, while it wasn't medically necessary when he was in prison, it became medically necessary when he was released; or Dr. Weber committed healthcare fraud by performing a procedure and billing for a procedure that's not medically

necessary; or Corizon's definition or the MDOC's definition of medical necessity is different from the definition used by the Michigan Medicaid program. Can you think of another possibility?

MR. SCARBER: I'm just going to place an objection to the form of the question and to speculation all over the question. Your question started out even with speculation on your behalf. So object to form, speculation. He can't answer that kind of question. But go ahead, if you can.

A I can't, there's too many variables. There's always a difference of opinion among medical providers. But I can't speak to the legalities of whether they committed a crime or fraud.

BY MR. CROSS:

Q Well, do you think it was medically necessary to reverse the colostomy after he got out if we assume that his condition was the same?

MR. SCARBER: Objection; asked and answered, calls for speculation, foundation.

A Again, you're asking me to speculate. I don't know.

BY MR. CROSS:

Q Well, what kind of information would you need to know?

A I'd want to see the surgeon's note prior to the

procedure, the nature of the procedure, what procedure was done; and even then, I mean, you're going to find difference of opinion among different surgeons. His previous surgeon, I understand, said it wasn't medically necessary.

Q Well, would it help you if I showed you the surgeon's note prior to the procedure? Would you be able to form an opinion then?

A Again, you're asking me to speculate?

Q Well --

A I can't do that.

Q -- didn't you testify earlier that you formed an opinion about whether a colostomy reversal was medically necessary for Mr. Jackson based on your review of some medical records in preparation for today's deposition?

MR. SCARBER: I'm going to place an objection; that mischaracterizes his testimony. And I don't want to make a speaking objection, but a lot more went into that answer.

A I believe I answered as to medical necessity and how that MDOC policy dictated what they would approve and what they would not.

BY MR. CROSS:

Q So you didn't have an opinion as to whether the

reversal surgery was medically necessary in April of 2017.

MR. SCARBER: You mean did he formulate an opinion in April of 2017?

MR. CROSS: No, I'm asking him does he have an opinion today that he was able to formulate, based on reviewing medical records from Mr. Jackson's time in the MDOC, about whether or not a colostomy reversal was medically necessary for Mr. Jackson.

MR. SCARBER: And I'm going to object, again, that it's been asked and answered repeatedly about what he thinks about that particular procedure, whether it should have been done or whether it was medically necessary or what the basis of his opinion already was concerning that. But I think the record will speak for itself that he's been asked that a number of times and given reasons as to his opinion. But go ahead.

A No, it did not meet the criteria for medical necessity.

BY MR. CROSS:

Q So why couldn't you determine, based on medical records from June of 2019, whether it met criteria for medical necessity at that time?

MR. SCARBER: I'm just going to place app objection, also, to, at this point, what difference does it make for this doctor, at this point, to be talking about something that happened well after this time period. But go ahead. He didn't make any decisions -- but go ahead.

A Yes, the decision would be the same based on the policy.

BY MR. CROSS:

Q The decision would be the same based on the policy, meaning, in June of '19, the decision would be the same?

A Unless this policy has been changed, yes.

Q Okay. So the determination of whether it's medically necessary or not is based on a policy of the MDOC.

MR. SCARBER: Objection; asked and answered, many times, and taken out of context of what his prior testimony was.

A So, again, my answer is the same, the MDOC base their policy on medical necessity.

BY MR. CROSS:

Q Is it possible that medical necessity in the MDOC context is different from medical necessity in the Michigan Medicaid program context?

MR. SCARBER: I'm going to place an objection; calls for speculation. The question itself asked him is it possible; anything is possible. But if you can answer.

A It's possible, but I don't have those Medicaid policies in my hands for review.

(Bomber Deposition Exhibit No. 10 was marked for identification.)

BY MR. CROSS:

Q Okay. Let me show you a document. We'll call this Exhibit 10. This is a declaration of Dr. Erin Orlebecke, and I believe you testified earlier that Dr. Erin Orlebecke trained you how to do utilization management activities; is that correct, sir?

A Yes.

Q And she was the state medical director before you were the state medical director; is that correct?

A Yes.

Q Okay. Now, down here on page six of the declaration, if we look at the bottom of No. 13, it says, "If a patient can hear out of one ear without a hearing aid, then no hearing aid is necessary for the other ear." Do you agree with that?

MR. SCARBER: I'll just place an objection, before the witness answers, as to we

don't know anything about this particular case at this point, what this is referring to, what the facts are, and what this doctor was actually responding to. But if you can answer, go ahead.

A I believe that the MDOC did have policies on hearing aid and replacement and what the criteria were for approval of hearing aids; that has changed throughout the years. So, at the time -- and Dr. Orlebecke didn't train me, per se, on this particular patient, but there was a policy at the time that we would follow.

BY MR. CROSS:

Q Do you know a Dr. Harriet Squier?

A Yes.

(Bomber Deposition Exhibit No. 11 was marked for identification.)

Q Okay. I'm going to show you what's been marked Plaintiff's Exhibit 11. This is a declaration of Dr. Harriet Squier, and here, at page six, she says, "Mr. Coates's examination suggested that he had very good hearing in the right ear; therefore, a hearing aid in the other ear would not add much benefit and there was no medical necessity for Mr. Coates to have a hearing aid."

Do you agree that there's no medical

necessity to have a hearing aid in one ear if you can hear out of the other ear?

MR. SCARBER: Same objection as before, but go ahead, with respect to the affidavit by -- or declaration by Dr. Orlebecke. But go ahead, so I don't have to repeat it, go ahead.

A I would have to know what Uptodate said at the time, as well as the MDOC policy.

BY MR. CROSS:

Q Okay. Do you know what Dr. Squier's job was when she worked in the MDOC?

A Yes, she worked for PHS, which became Corizon, as a utilization management physician.

Q And you started doing utilization management at the point that she retired; is that correct?

A Yes, I believe that was around the time I left.

Q And then who took over from you?

A Dr. Papendick replaced Dr. Squier.

Q Okay. So, fair to say, at some point in, you know, 2012 to 2014, it was not considered medically necessary for a prisoner to hear out of both ears?

MR. SCARBER: I'm going to place an objection. He has already said he would have to review a policy -- objection; calls for speculation, foundation. Go ahead.

A Yeah, I'm sure that, at the time, Uptodate and MDOC policy spelled out what type of hearing loss required corrective aids, but I don't remember the details.

BY MR. CROSS:

Q Is there a risk of death associated with getting a hearing aid?

A Not that I'm aware.

Q Okay. Are there some benefits to being able to hear out of both of your ears?

MR. SCARBER: Just going to place an objection to relevance as well. Go ahead. It has nothing to do with the medical issue we're talking about here. But go ahead.

A Yes, it's better if you have hearing from both of your ears.

BY MR. CROSS:

Q Okay. So, from the patient's perspective, is it possible that the benefits of a hearing aid outweigh the risks?

A It's possible.

Q Okay. So, do you think the utilization management department is considering something else besides the risks versus the benefits to a patient of a particular procedure?

MR. SCARBER: Calls for speculation. He wasn't involved in any of those cases. But go ahead.

A No, I wasn't involved in determining that policy. But I know that it was a joint process between Corizon and the DOC.

BY MR. CROSS:

Q Can you answer the question that I asked you, sir?

A Can you repeat the question.

MR. CROSS: Ms. Hicks, can you repeat that question.

(Page 88, lines 22-25 were read back.)

A Can you tell me what "something else" means?

Q Well, I'm asking you that, sir. Are they considering something besides a risk-to-benefit analysis?

A Well, they're considering what the MDOC thinks about the issue, as well, and what their policy is.

Q Okay. You talked before about Uptodate and the need to establish that the treatment -- that there's evidence to support the treatment, right? That's part of medical necessity?

A Correct.

Q Do you know if there's evidence that hearing aids

help with hearing loss?

MR. SCARBER: I'll place another objection to relevance, particularly with respect to this issue. It has nothing to do with the Monell claim that we're talking about here or possible Monell claim. Go ahead.

A I would have to read up on the benefits of hearing aids. Sorry, I don't know off the top of my head.

BY MR. CROSS:

Q So I'm just -- it seems to me like there's something else being considered besides a risk/benefit analysis and whether the procedure is supported by evidence, at least in this case with the hearing aide. Do you agree with that?

A Not that I'm aware of, no.

Q So those are the only things that are being considered, is whether it's A1 evidence that the procedure helps the problem and the risks to the patient and the potential benefits to the patient?

MR. SCARBER: Just going to place an objection, asked and answered. Go ahead.

A That's how I practice medicine, yes.

BY MR. CROSS:

Q You practice outside of a prison as well, correct?

A Yes.

Q Do you look at MDOC policies when determining whether a given test or procedure is medically necessary for your non-prisoner patients?

MR. SCARBER: I'm just going to place an objection to relevance. We're not talking about what this particular doctor does outside of what's involved in the treatment of Mr. Jackson, who, at the time of his lawsuit, was an inmate in the county jail, as well as a prisoner in the Michigan Department of Corrections. So we're not -- it's irrelevant to the issue in this case. Go ahead.

A I do not use MDOC policy outside of the MDOC.

BY MR. CROSS:

Q So are there things that might be medically necessary outside of the MDOC that wouldn't be medically necessary inside the MDOC?

A It just so happens that what I use out in the world is Uptodate, it's very similar.

Q But Uptodate is not the only thing you use inside the MDOC, right?

MR. SCARBER: Asked and answered. But go ahead.

A No, they also use InterQual, National Cancer Coalition data, and then sometimes a literature search is done, too, to see if there's anything new

and current.

MR. CROSS: All right. I don't have further questions. Thank you for your time, sir.

MR. WILLIS: I don't have anything.

EXAMINATION

BY MR. SCARBER:

Q Doctor, I have one question for you. Specifically, when you were talking about the appeals procedure with respect to a final determination as to whether or not Mr. Jackson would have a colostomy reversal or not, who has the -- who makes the final determination as to whether or not that procedure would be done?

A The final determination is made by the chief medical officer of the Michigan Department of Corrections.

Q Corizon is not the final decision-maker with respect to that procedure?

A That's correct, Corizon is not.

MR. SCARBER: I don't have anything further.

MR. CROSS: I have some follow-up.

EXAMINATION

BY MR. CROSS:

Q Does Corizon have any policies about what is medically necessary?

A No, because we're told -- we're instructed to use Uptodate. They have clinical modules -- I mentioned that earlier -- for diabetes, hypertension, prostate cancer. But they're just modules based on the evidence, and, on a day-to-day basis, we're instructed to use Uptodate. Corizon pays for that for all of its providers.

Q Well, does Corizon instruct its providers at all about what's medically necessary and what's not medically necessary?

A Yeah, based on what's in Uptodate and what the policies of the MDOC are. But there's no Corizon policy saying, 'Hey, you need to approve this for this and not this.' There's nothing like that.

Q Let's go back to the exhibit we talked about before, "Practitioner Clinical Onboarding"; and one of the modules here under "Utilization Management" is called "Determining Medical Necessity"; and did you testify that you provide that training?

MR. SCARBER: Hey, Ian, you've got the wrong exhibit up, I'm sorry.

MR. CROSS: What do I have up?

MR. SCARBER: You got a declaration up. Just maybe go back a few.

MR. CROSS: Hold on.

MR. SCARBER: While you're getting it, I'm just going to note this is -- I thought this wasn't, but now it's clear that this is outside the scope of what I had asked the witness in my one question. So it's outside the scope of my direct of the witness. But go ahead.

BY MR. CROSS:

Q You train people about that, determining medical necessity?

MR. SCARBER: Place an objection, asked and answered, about maybe an hour-and-a-half or so ago. But go ahead.

MR. CROSS: Yeah, I don't remember what he said.

MR. SCARBER: Okay.

A Sure. The answer is that yes, we direct them to Uptodate and the other resources available for medical decision-making.

BY MR. CROSS:

Q And so all you tell them to do to determine medical necessity is look at Uptodate?

A Uptodate, National Cancer.

Q Cancer.

A The same. There's no Corizon policy like that. We're using Uptodate 'cause it's current

information, it's dynamic.

Q Okay.

MR. SCARBER: And let me just place another objection to all -- he's already answered all of the various things that go into determining medical necessity for a particular patient in his testimony over the last couple of hours. But go ahead.

BY MR. CROSS:

Q Your testimony is that there's no Corizon definition of medical necessity anywhere that's given to the providers?

A Not -- when I train my providers, I show them Uptodate, we review it, there are -- there's no, something similar to Uptodate, that Corizon has that I'm aware of.

In the training manual, there are a couple statements about medical necessity. But there's no, like, algorithm or rules for making a decision inside Corizon outside of that. So, no, I'm not sure what, you know --

Q But there's something in the training manual about determining medical necessity.

A Yeah, there are some guidelines.

MR. CROSS: Okay. Thanks. That's

all I have.

EXAMINATION

BY MR. SCARBER:

Q With respect to whether there are guidelines in the training manual determining medical necessity or not, is there any specific direction or order that Corizon gives to its medical providers or reviewers limiting their ability at all -- and I'm not talking about MDOC policy, but I'm talking about something from Corizon -- limiting their ability to be able to factor in the things that they feel are important for medical necessity?

A No, quite the contrary; in fact, we tell them if you find something outside of Uptodate in the medical literature -- for example, sometimes new things came out in "The New England Journal" or "The Journal of American Medicine" that Uptodate was a little behind on -- and we considered that information as well. So, no, they're never limited.

Q And is the patient's presenting condition and symptoms something that is also very important in determining whether something is medically necessary for that particular patient?

A Yes.

Q And if the patient, in this particular situation,

has a functional colostomy and no complaints of physical issues or pain or any type of suffering related to that particular colostomy, would that be something that would be considered in determining whether it was medically necessary?

A Yes.

Q In addition to all of the other factors that you already spent time discussing here.

A Correct.

Q Again, these are factors; is that correct?

A Yes, sir.

MR. SCARBER: I have nothing further.

EXAMINATION

BY MR. CROSS:

Q Doctor, do you have an understanding of what prisoners are entitled to under the Eighth Amendment in terms of health care?

MR. SCARBER: All right, I'm going to place an objection; that's way outside of the scope of my redirect at this point. So what do you want to do?

MR. CROSS: Are you going to instruct him not to answer?

MR. SCARBER: I'm going to place a very, very strong limit on what we discuss after

this point, if you got one question or something like that, but now this is going in a whole other direction. This is not follow-up. This is stuff that could have been covered on your direct or cross. Go ahead.

A It's been some time since I've read the Eighth Amendment. But the bottom line is inmates are entitled to the same standard of care as that as available in the community. So I'd have to go back and look at the Eighth Amendment.

MR. SCARBER: And I'm going to place an objection that it calls for a legal conclusion.

BY MR. CROSS:

Q Okay. Now, Devlin, your attorney just asked you some questions about the factors that Corizon providers consider when they are determining whether a colostomy reversal is medically necessary, like is the patient in pain or having issues with the colostomy. Are those the same things that a provider would consider in the community when determining whether a colostomy reversal is medically necessary?

MR. SCARBER: Place an objection to foundation. But go ahead.

A Yes.

BY MR. CROSS:

Q So if you were at a community hospital and someone came in with a functional colostomy, you would say, 'I'm not going to refer you to a surgeon because you don't need this to be reversed'?

A I definitely would explain the medical necessity and the risks versus benefits of any procedure.

Q But would you refer them to a general surgeon or no?

A Yeah, if a patient came to me requesting -- any procedure, really -- and if they were adamant that they wanted to see a specialist, absolutely I would facilitate that.

MR. CROSS: Okay. I don't have any further questions. Thank you, sir.

MR. SCARBER: I have a follow-up question.

EXAMINATION

BY MR. SCARBER:

Q Is it true that Mr. Jackson was incarcerated at the time of this particular event that he's talking about, his colostomy reversal request?

A Yes.

Q Mr. Jackson was not on the -- in the outside community, was he?

A Not at that time.

Q Were there any specific -- and I think you've already testified -- but there was not an MDOC policy involved in that particular determination as to when he was on the outside of the medical community?

A I don't believe so.

Q I'm sorry, on the outside of the Department of Corrections.

A No.

Q And you testified earlier about your understanding of the Eighth Amendment. Were you speculating about the Eighth Amendment and what the legal requirements were?

A It's been a long day and I'm just drawing a blank there.

Q All right. Do you have an understanding that under the Eighth Amendment Mr. Jackson would have to demonstrate a serious medical need for a particular procedure?

A Thank you for reminding me; yes.

Q Would it also be your understanding that he would have to have a serious medical need that was willfully ignored or disregarded by a healthcare professional that caused him some kind of harm, substantial harm, with respect to whether or not a

procedure was done?

A Yes, thank you, that's what I recall now.

Q Are you aware, from any records that you've reviewed, of seeing a serious medical need for a colostomy reversal demonstrated, by Mr. Jackson in this particular case, during the time of his incarceration in the MDOC?

A I am not.

Q Have you been advised of any serious physical harm or pain or suffering in any physical manner that was experienced by Mr. Jackson as a result of not getting a colostomy reversal in the MDOC?

A I am not.

MR. SCARBER: I have nothing further.

MR. CROSS: All right. I don't have anything further.

MR. WILLIS: Nothing for me. Thank you.

THE VIDEOGRAPHER: This concludes the deposition. The time is 1:40 p.m.

(The virtual, videotaped deposition concluded at 1:40 p.m.)

CERTIFICATE OF NOTARY

STATE OF MICHIGAN)

) SS

COUNTY OF LIVINGSTON)

I, Carol Marie Hicks, Certified Shorthand Reporter, a Notary Public in and for the above county and state, do hereby certify that the above deposition was taken before me at the time and place hereinbefore set forth; that the witness was by me first duly sworn to testify to the truth, and nothing but the truth, that the foregoing questions and answers made by the witness were duly recorded by me stenographically and reduced to computer transcription; that this is a true, full and correct transcript of my stenographic notes so taken; and that I am not related to, nor of counsel to either party nor interested in the event of this cause.

_____

Carol Marie Hicks

CSR 3345 Notary Public,

Livingston County, Michigan

My Commission expires: September 4, 2021